Midwives in ante and postnatal care

European experiences

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Midwives in ante and postnatal care

- European experiences

Contents of this talk

- Midwives in modern maternity care services:
  - Broading of the ante and post natal role of midwives
  - Midwifery led care: what it is and how it compares to other models of care internationally
  - Midwifery the Nordic and Danish way

- Reorganising birth services:
  - Key issues in efficient, high quality care for women and families – continuity, competence, collaboration

Broadning of ante natal roles

Although there are HUGE variations, the field of midwifery is broadening and we now se midwives providing:

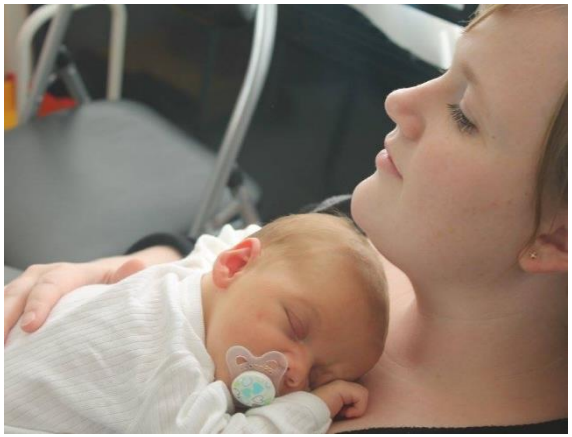
- Autonomous antenatal care for low risk women including childbirth and parental education (some in private practice)
- Shared antenal care for high risk women
- Specialised shared care for pregnant women with complex medical needs (twins, heart disease, diabetes ect.)
- Counselling for eg. women with fear of childbirth
- Counselling couple with marial or sexual health problem
- Specialised shared care for pregnant women with complex psycho-social needs (vulnerable women)

Postnatally and other:
Care in relation to women's general health care needs related to their reproductive and sexual life circle

- (contraception, screening – community based or employed by a general practitioner)

- Shared care in antenatal hospital wards for women with complications

- Ultrasound scans (after having sonographic training):
  - Rutine scans i relation to screening malformations (hospital)
  - Scans on indication (e.g. assessment of fetal growth)
  - Non-medically indicated scans for fetal wellbeing in *private practice*



- Autonomous postnatal care for low risk women:
  - Familiy units in "patient-hotels"
  - Who are early discharged from hospital

  - Private, midwifery led/owned post natal clinic
  - Freelance post partum councelling related to breastfeeding, sexual health, family health *(private practice)*

Why is this happening?

On the positive side:

- more midwives have access to specialised / high level training and use their skills to improve health and wellbeing
- Greater awareness of midwive's competences

On the negative side:

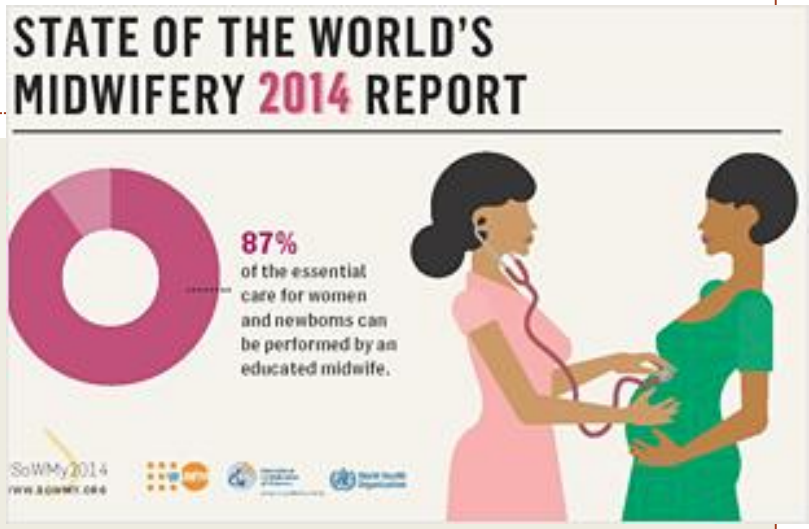
- In Denmark: care for low risk is reduced, care for vulnerable and high risk is increased and specialsed

- cut backs in the public budget:
  - leaving women and new parents with care needs that are unattended by the public service.
  - Reducing public services to a level that is unacceptable to midwives (burnout and loss of public midwives)

Facts in Danmark and many other European

- Funding of public health care services are being cut – often 5 % reduction of budgets year after year.
  - Health care needs are not reduced: ***we must do more for less***
- Services are being centralised and units are getting larger
- Lack of continuity (staff is moved around to fill gaps)
  - Women often see different midwives (and doctors) during pregnancy
  - Discontinuity of care is associated with loss of information, less attention to patient needs, delay of appropriate action: concern for patient safety!
- The distribution of services is inequal and inappropriate:
  - those most in need may get too little
  - others (especially in private obstetric-led care) may get more than is good for them (overuse where benefits does not outweigh harms)

WHO recommandations



Strengten the use of midwives
and midwifery-led care

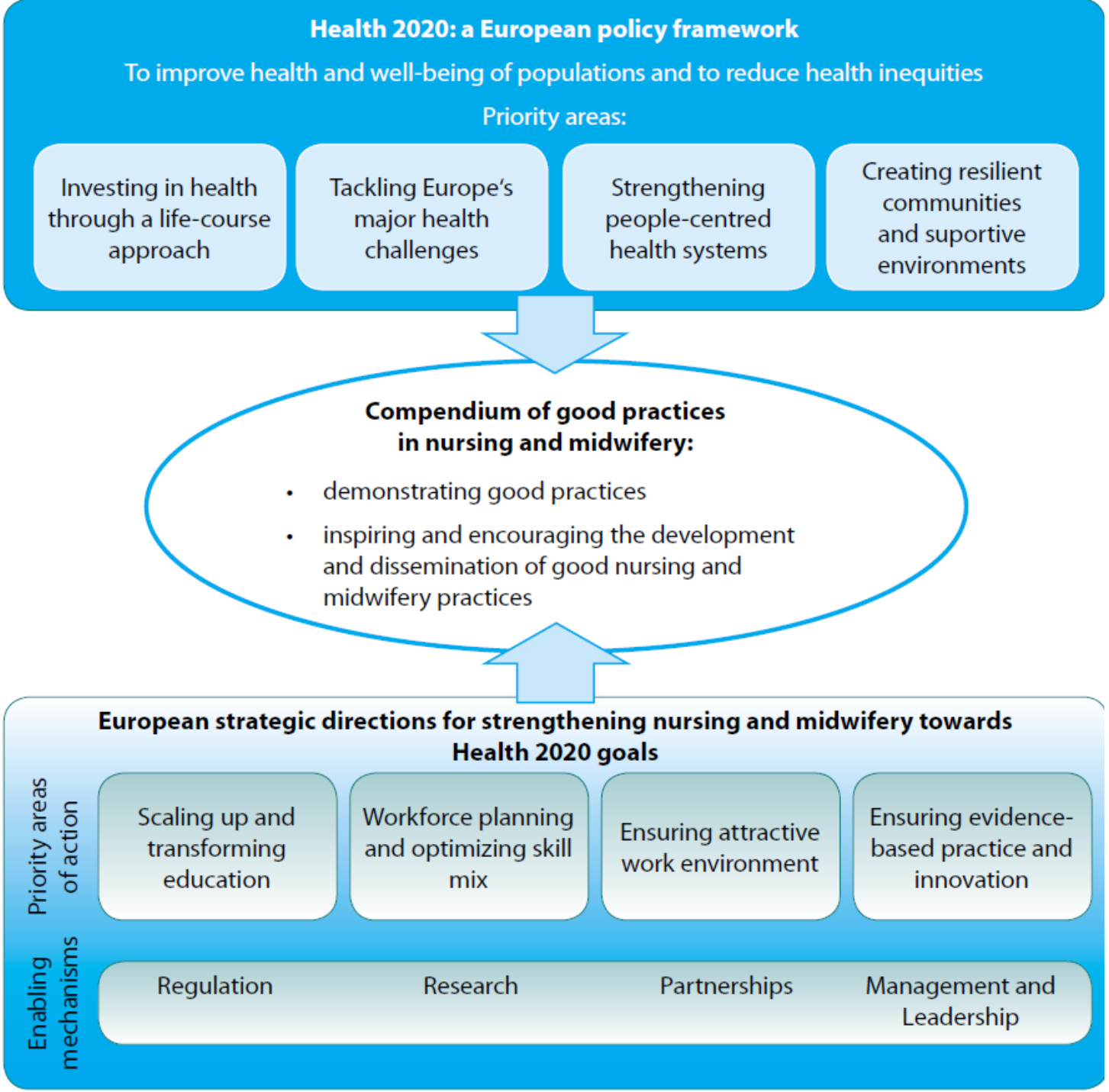
- 2020 strategi: "Vital ressources for health"

Important fundation for this is:

- The Lancet 2014 series on Midwifery:
  1. *Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care.*
  2. *The projected effect of scaling up midwifery.*
  3. *Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality.*
  4. *Improvement of maternal and newborn health through midwifery.*

- A opdated Cochrane Review of randomised controlled trials of midwifery led care (Sandall et al. 2013)

Facilitation evidence-based practice in midwifery in the who european region, 2015 Jylha et al



So: there is a policy push for midwifery-led care - but what it that exactly?

A care model where:

- *a midwife is the lead professional in the planning, organization, and delivery of care throughout pregnancy, birth, and the postpartum period*

Midwifery led care is NOT about pushing out obstetricians or providing "loving" but unsafe care.

A helpful focus may be:

" Every woman needs a midwife,
and some women need a doctor too" *(Sandall 2013)*

How do midwifery-led continuity models of care compare to medically-led or shared care?

Cochrane Review of randomised, controlled trials show that:

Women in midwifery-led continuity models compared to hospital-led care are:

- Less likely to experience:
  - overall fetal/neonatal death
  - preterm birth
  - regional analgesia, episiotomy, and instrumental birth
- More likely to
  - experience spontaneous vaginal birth
  - feel in control during childbirth
  - initiate breastfeeding

Significant benefits for mothers and babies without showing any **adverse effects** Furthermore, a cost-saving effect has been seen (may depend on heath care system).*See: Sandall et all 2013 (Cochrane Review), Devane et al 2012.*

Midwifery the Nordic way

- Midwifery is a cultural and historical institution in the Nordic countries
- More than 300 years for regulations for midwives
  - Sweden 1711
  - Denmark & Norway 1714

Jordemødre
300 år med autorisation

- Until recently (10-20 years ago): trained and examined by doctors/obstetricians (now an autonomous profession working independently within a set of regulations)

- **In all Nordic countries:**

  low level of interventions, low maternal and perinatal (<6/1000) mortality

- Authorized by the state to provide **autonomous care for women at low obstetric risk during pregnancy, birth and the post partum – in hospital and out of hospital**
  - Midwives may set up their own practice/clinic but most are employed at an obstetric unit
- Close interprofessional collaboration

Childbirth in Denmark – a few facts

- A population of approx 5.000.000 people
  - (the North Denmark Region approx. 500.000)

- Approx 60.000 births
  - 3% home; 1% freestanding midwifery unit; 96% obstetric unit
  - Perinatal mortality 6/1000; caesarean section 20%

- All childbirth and health care services are free (tax paid)
  - >99% of women attend the Danish pregnancy program:
    - ALL women have **shared care in pregnancy** between midwife (key professional, 4-7 visits) and general practitioner (3 visits)

    - All women offered pregnancy screening for fetal malformations:
      - 2 scans – week 12 + week 20 and blood test.
      - NO RUTINE scans for fetal growth
    - ONLY high risk women see an obstetrician (or specialised midwife)

Midwifery in Denmark

- Trained in a 3.5 year direct-entrance Bsc. program
  (Danish midwives are not nurses)
- No routine use of cardiotocografi (CTG) during birth
- No obstetrician or paediatrician routinely present at/after birth
- Midwives are authorised to independently:
  - give medication to stop post partum bleeding
  - give pain relief for and perform suturing of 1 + 2 degree perineal tears
  - initiate resuscitation / emergency treatment of mother and child

  (no other prescriptions unless authorised by e.g. the obstetric head of department)
- Many midwives do *antenatal care 1 day a week* and *labour ward 4 days*
- Last 10 years: continuity models of care has come into focus

Why is continuity so important
- Let's get "confortable" with the concept:

four forms of continuity exists – all vital to high quality care

1) A stated staff commitment to a **shared philosophy of care**

2) Continuous carer responsibility

- Same midwife all though birth – BUT she may care for two or more women at the same time

3) **Continuous midwifery support** during labour

- A midwife is present with the woman all through birth – **one to one care** (but maybe not the same midwife)

4) **Continuity/"knownness" of carer** (caseload midwifery)

- Care throughout pregnancy, labour, birth and the postnatal period is provided by same or a small group of 2-3 midwives

Caseload midwifery

Widely used in Denmark

- introduced small scale in almost all Danish obstetric units
- Introduced large scale in a few units (approx ensured for 1/3 af the women)
- **One** small obstetric unit is run exclusively by caseload group

Included in NICE guidelines from England and included in national policies

Not yet prioritised **in Sweden** – but there is a push for it

Not the rule in **Norway, but** in rural / sparsely populated regions, the local midwife may: arrange transfer to hospital, do intrapartum care, transfer the low risk women back to provide post partum care in her home/a local clinic.

What form is most important?

No consensus in the literature on which aspect is most important

- however strong evidence to support point 3 (continuous support) and 4 (known midwife).

All four forms can – and should - be provided simultaneously:

1. Shared care philosophy among staff
2. Same midwife all through birth
3. Continuous support/one-to-one care all though labour
4. Known midwife: continuity of carer though pregnancy-birth-post partum

A peek at preelimnary results from work in progress on the impact of continuity af intrapartum carer (please do not cite)

(removed from this public version of the presentation)

Points for consideration in the reorganisation of your maternity care services

The province of Trento is doing amazingly well in this process of change. Let med remind you - in times of change – and especially when changes include professional competences and roles:

- The chance of success is lower if several changes in organisational structures occur simultaneously.
- Learnings from a Danish context and the literature:
  - Be patient
  - Be respectful, listen to arguments
  - Good training of new competences is crucial, feedback and peer support
  - Participate in joint training activites – read and discuss the same evidence
  - Carry out interprofessional audit sessions
- Continuity of care throughout pregnancy, birth and the post partum holds great potential for improvement of health and well-being among low risk women (and high risk women too..

Thank you for listening!

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